Ingrezza® Referral Form

(valbenazine) capsules

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

First Name		Last Name		Date of Birth			
Address		City		State		ZIP	
Last Four Digits of the SSN		US Resident:	☐ Yes ☐ No	Gender:	☐ Male ☐ Female		
Preferred Phone		Is Preferred Phone a mobile number?	☐ Yes ☐ No	Email			
Alternate Contact/Care Partner		Alternative Contact/Care Partner					
Patient/Authorized Representative Signature				Date			
Description of Authorized Representative's Authority:							
(Optional) I consent to have my prescription shipped to:	☐ Care Partner	☐ LTC	☐ HCP Office	☐ Group Home			
Patient Residence Category	☐ At Home	☐ LTC	☐ Group Home	☐ Other			

Patient Insurance Information

Medical Insurance Name		**Prescription Insurance Name**			
Card Holder ID #		Card Holder ID #			
Policy Holder Name:		Bin#:		PCN	
Phone:	Policy Holder DOB	Rx Group #:		Phone	
Payer Type	☐ Commerical ☐ Medicare ☐ Medicaid ☐ Other ☐ Patient Does Not Have Insurance				

Financial Information

Total Monthly Gross Household Income: $		Number of People Living in Household:	
Select Your Sources of Income: Salary/Wages	☐ SS Pension/Unemployment ☐ Alimony/Child Support ☐ Retirement ☐ SSDI ☐ SSI ☐ No Household Income ☐ Other _____ (Income subject to verification)		

Clinical Information

Primary Diagnosis Code Category:	☐ Tardive dyskinesia (G24.01) ☐ Huntington's chorea (G10) ☐ Other Diagnosis _____ ☐ Allergies _____

Prescriber For INGREZZA (valbenazine) Capsules

Initial RX	Maintenance Rx
☐ 40 mg once daily x 7 then 80 mg once daily x 21	☐ 40 mg once daily, 1-month supply
☐ 40 mg once daily x 14 then 60 mg once daily x 14 (Huntington's chorea)	☐ 60 mg once daily, 1-month supply
No Refills.	☐ 80 mg once daily, 1-month supply Refills # _____

☐ Other Rx Sig: _____ Quantity _____ Other Rx Refills _____

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Prescriber Insurance Information

I certify that the information provided in this INGREZZA® (valbenazine) capsules Patient Assistance Program (the "PAP") Application is complete and accurate to the best of my knowledge, I have prescribed INGREZZA based on my judgment of medical necessity, and I will supervise the patient's medical treatment. I certify that, where required by law, I have obtained my patient's written legal permission to share identifiable information with Neurocrine Biosciences, Inc. and the INBRACE Support Program Pharmacy. I authorize the forwarding of this prescription and information to the INBRACE Support Program Pharmacy. I understand that neither I nor the patient, LTC facility, or pharmacy may seek reimbursement for any free or discounted product received under the PAP. Patients are not eligible for the PAP if their insurance plan or employer participates in an alternate funding program (also sometimes referred to as patient advocacy program, alternative access program, or specialty network) requiring the patient to apply to a manufacturer's patient assistance program or otherwise pursue specialty drug prescription coverage through an alternate funding vendor as a condition of, requirement for, or prerequisite to coverage of relevant Neurocrine products, or that otherwise denies, restricts, eliminates, delays, alters, or withholds any insurance benefits or coverage contingent upon application to, or denial of eligibility for, specialty drug prescription coverage through the alternate funding program. Patients also are not eligible if such a plan or program changes or hides the patient's insurance coverage to make the patient appear to be underinsured and eligible for the PAP. The PAP requires the healthcare provider or facility to retain proof of patient income on file in their office. For the purposes of an audit, the PAP may ask for a copy of the patient's IRS 1040 form or other proof of income. I agree to notify the PAP if I become aware at any time in the future of changes in my patient's circumstances that would affect eligibility, including but not limited to changes in health insurance status or coverage, financial status, or United States residency status. I understand that Neurocrine Biosciences, Inc. reserves the right to change or terminate the PAP at any time.

Prescriber Name		NPI#		Office #		Fax #	
Address		City		State		Zip	

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

☐ DAW (Dispense as written).

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.

Date

Prescriber's Signature

X _____